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ABSTRACT

The Cantril-Kilpatrick Self-Anchoring Technique (1960) was used to assess self concepts of visually impaired persons by performing a numerical evaluation of visually impaired persons' self ratings and a content analysis specifying dimensions used by the individuals in rating themselves. A total of 577 persons participated. Results showed that the majority of clients placed themselves at the middle of the scale. It was also found that the noncongenital group consistently rated themselves higher at the positive end of the scale. Younger clients were reported to have better self concepts than those individuals 30 years of age and over. Analysis of data included descriptive comparisons between clients interviewed in the field and those in the clinic, comparisons between races, age categories, sexes, degrees of residual vision, age at onset of visual impairment, the length of impairment, and education categories; some emphasis was placed on rural distinctions. (CB)

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USE OF A SELF-ANCHORING TECHNIQUE IN ASSESSING SELF-CONCEPTIONS OF VISUALLY IMPAIRED PERSONS

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The sociological literature on persons with visual impairment is indeed scant (Goldberg and Swinton, 1969; Himes, 1958, 1960; Lowenfeld, 1964; Rawls and Rawls, 1968; Scott, 1969). This does not mean, of course, that the literature on the blind is small, because it is vast, with many agencies publishing materials on this subject continuously. The emphasis that we wish to make here is that the study of visually impaired persons, from a sociological standpoint, (particularly from a standpoint of residential differentials), is scant. It is the belief of the authors that this is an area holding much promise, not only for so-called applied sociological endeavors, but perhaps more importantly having implications of a theoretical nature concerning person perception and self-other roles, as these are to be found in communities of various sizes throughout the world.

The limited study discussed below is an attempt to break away from the standardized attitudinal and interest scales, with all of their urban biases, and to introduce a technique specifically adapted to the perceptually impaired person. This is done employing a well developed and well publicized technique: i.e., the Cantril-Kilpatrick Self-Anchoring Technique (1960), which, it is hoped, will lend that degree of flexibility which will make it possible to perform not only a numerical evaluation of visually impaired persons' self-ratings, but also a content analysis showing exactly what dimensions individuals are employing in rating themselves.

The sample utilized in the study was obtained as a part of a sizeable project involving the Federal Vocational Rehabilitation Administration, the N.C. State Commission for the Blind, and the Department of Sociology and Anthropology, N.C. State University at Raleigh.* In all, 577 cases were intensively interviewed either at the Raleigh Lions' Clinic for the Blind, a combination clinic and work acclimatization center, or in the field where clients who had attended the Clinic are now located. One additional word about the Clinic is that it is partially funded by contributions from Lions' Clubs throughout the state of North Carolina, and federal funds administered by the N.C. State Commission for the Blind.

Analysis of the data will involve descriptive comparisons between clients interviewed in the field and those in the Clinic, comparisons between races, age categories, sexes, degrees of residual vision, age at onset of visual impairment, the length of impairment, and education categories; some emphasis is placed on rural distinctions.

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SOME THEORETICAL CONSIDERATIONS

The adult personality characteristics of an individual are to some extent products of interaction with his social environment, or the consequences of his life's roles and his self-concepts. Roles are usually structured within a culture and much agreement exists as to what behaviors are expected from members of a specific group (Parsons, 1951). As Robert K. Merton (1957:198) points out, the individual in a group is under pressure, by his group, to become disciplined, rigid, and unable to adjust readily to new situations (1957:199). In this way, one's orientations toward a role become integral parts of one's personality, and, similarly, of one's sense of self. This happens with the visually impaired in that they are encouraged, by society and it "helping" institutions, to believe that they should be dependent and obligingly accept their lot--though it is an inferior one (Scott, 1969).

Thus, by being encouraged and sometimes forced to play a dependent or compliant role, the visually impaired person eventually sees himself as necessarily dependent upon almost everyone with whom he comes in contact. Because of the special kinds of interactions with their social environments, and because of the roles they are encouraged to play, the visually impaired learn to have a sense of self different from, and perhaps less psychologically mature than, normally sighted persons, as many authors suggest. The totally blind or the partially sighted individual views himself as he perceives others reacting to him, whether or not his perception is accurate; this capacity to see oneself as an object turns into a set of beliefs and attitudes about oneself--the self-concept (Davis, 1964; Bauman, 1959).

George Herbert Mead (1934), a social psychologist, believed that the mind has to be explained in terms of the interaction of the organism with the environment. His thoughts on symbolic interactionism helped lead to the idea of the development of the self by making the assumption that one must be able to anticipate the response one's act elicits from another person: one does this by taking the role of the other, and by viewing oneself from the points of view of other persons. Therefore, the self, for Mead, "...is not initially there, at birth, but arises in the process of social experience and activity" (1934:135).

Deutsch and Krauss (1965:188-189) elaborate on Mead's concept of the unique self, that which has "its own particular individuality, its own unique pattern" (Mead, 1934:202), and suggest that individuals develop different self-concepts depenting upon what happens to them in the course of their lives. Erik H. Erikson (1950; 1959) discusses the importance of psychosocial stages of ego development for self-concept formation, and he reviews and amplifies Freud's (1938) concept of a psychosexual developmental sequence. Ego development and ego-alienation are of concern to Robert Merton (1957) as well, who discusses both the Durkheimian phenomenon anomie (Durkheim, 1912) and the social-psychological concept "anomia" (Srole, 1956). J.S. Himes (1958; 1960) and John F. Scott (1968) also refer to anomie and consider it to be one aspect of the social-psychological reaction of the visually impaired to social relations taking place in their lives. They generally conclude that the perceptual disorder itself invariably produces major personality problems.

Howard Becker (1960) discusses anomie also, and sees efficient social functioning as preserving, maintaining, and restoring the norms and normative systems of a given society. According to Becker, anomie can result when a social system does not successfully preserve its normative system. Other authors, as well as those cited above, concern themselves with self-concept and anomia, and in what ways these phenomena are related to social variables in the adjustment of the visually impaired. Some of the pertinent variables to be looked at below, and others that will be analyzed at a later time, are thought to be related to both self-concept and visual impairment. A considerable amount of space has been given to elementary concepts of the self, but our main purpose is constructing a social psychology of the impaired or disabled individual, and it is our feeling that these notions in symbolic interactionism are given a particular acuteness when dealing with people of impaired sensory modalities.

We think that all of the extensive problems of self and self-other relationships so elaborately developed by writers from William James to Howard Becker to the transactionalists are encapsulated in the problems of visually impaired persons. It is our belief that the Cantril-Kilpatrick Self-Anchoring Technique (1960) makes it possible to expose to scientific scrutiny these processes. The section that follows departs from these theoretical considerations to simply describe various demographic and socio-cultural variables; these should be viewed, however, as representative of real self-conceptual problems and the stresses that accompany them, in some instances even to the point of anomia and medical disorders, of a social psychiatric nature.

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Descriptive Results

In this section, simple descriptions of variables thought to be associated with the self-concepts of visually impaired persons are presented in tabular form. In future analyses (especially theses and dissertations) qualitative and quantitative statistical measures will be utilized for assessing tests of generated hypotheses. In Table 1, the distinction between clinic and field interviews is looked at, in regard to self-anchoring scores:
(Text continued on page 9.)

Table 1. Self-Anchoring Scores for Clinic and Field Interviews

	1	2	3	4	5	6	7	8	9	10	
	N	%	N	%	N	%	N	%	N	%	TOTAL
CLINIC	(3)	0.5	(6)	1.1	(7)	1.3	(5)	9.2	(12)	9.4	7.9	(10)	9.0	(62)	11.2	(93)	16.8	(323)	67.3
FIELD	(0)	0.0	(5)	0.9	(2)	0.4	(3)	0.5	(21)	5.8	(17)	3.1	(21)	3.8	(24)	4.1	(18)	3.2	(50)	9.0	(181)	32.7
TOTAL	(3)	0.5	(10)	1.8	(8)	1.4	(8)	1.4	(33)	14.8	(29)	11.2	(31)	11.7	(84)	15.2	(80)	14.4	(143)	25.8	(554)	100.0

$N_2 = 12.509$, 9 df.

Table 2. Self-Anchoring Scores for Clinic and Field Clients by Some Descriptive Variables

	1		2		3		4		5		6		7		8		9		10	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
SOME COLLEGE	(1)	0.2	(5)	0.9	(6)	1.1	(10)	1.8	(50)	9.0	(59)	10.7	(50)	9.1	(70)	12.7	(63)	11.4	(112)	20.3	(446)	80.1
NO COLLEGE	(2)	0.4	(5)	0.9	(2)	0.4	(0)	0.0	(15)	2.7	(10)	1.8	(15)	2.7	(14)	2.5	(17)	3.1	(31)	5.6	(111)	19.9
TOTAL	(3)	0.5	(10)	1.8	(8)	1.4	(10)	1.8	(65)	11.7	(69)	12.5	(65)	11.8	(84)	15.2	(80)	14.4	(143)	25.8	(557)	100.0

$N_2 = 14.250$, 9 df.

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Table 3. SELF-ANCHORING SCORES FOR EACH CATEGORY OF THE SCALE FOR 546 BLIND CLIENTS BY CONGENITAL OR NON-CONGENITAL VISUAL IMPAIRMENT

	1 (N) %	2 (N) %	3 (N) %	4 (N) %	5 (N) %	6 (N) %	7 (N) %	8 (N) %	9 (N) %	10 (N) %	TOTAL
CONGENITAL	(3) 0.5	(5) 0.9	(2) 0.4	(5) 0.9	(29) 5.3	(28) 5.1	(22) 4.0	(33) 6.0	(24) 4.4	(53) 9.7	(204) 37.4
NON-CONGENITAL	(0) 0.0	(5) 0.9	(6) 1.1	(5) 0.9	(51) 9.3	(38) 7.0	(43) 7.9	(50) 9.2	(56) 10.3	(88) 16.1	(342) 62.6
TOTAL	(3) 0.5	(10) 1.8	(8) 1.5	(10) 1.8	(80) 14.7	(66) 12.1	(65) 11.9	(83) 15.2	(80) 14.7	(141) 25.8	(546) 100.0

$\chi^2 = 10.085$, 9 df.

Table 4. SELF-ANCHORING SCORES FOR EACH CATEGORY OF THE SCALE FOR 554 BLIND CLIENTS, BY SEX

	1 (N) %	2 (N) %	3 (N) %	4 (N) %	5 (N) %	6 (N) %	7 (N) %	8 (N) %	9 (N) %	10 (N) %	TOTAL
MALES	(2) 0.4	(9) 1.6	(4) 0.7	(6) 1.1	(57) 10.3	(47) 8.5	(44) 7.9	(56) 10.1	(54) 9.7	(98) 17.7	(377) 66.1
FEMALES	(1) 0.2	(1) 0.2	(4) 0.7	(4) 0.7	(25) 4.5	(22) 4.0	(21) 3.8	(28) 5.1	(26) 4.7	(45) 8.1	(177) 31.9
TOTAL	(3) 0.5	(10) 1.8	(8) 1.4	(10) 1.8	(82) 14.8	(69) 12.5	(65) 11.7	(84) 15.2	(80) 14.4	(143) 25.8	(554) 100.0

$\chi^2 = 3.90$, 9 df

Table 5. SELF ANCHORING SCORES FOR EACH CATEGORY OF THE SCALE FOR 5524 BLIND CLIENTS, BY RACE

	1 (N) %	2 (N) %	3 (N) %	4 (N) %	5 (N) %	6 (N) %	7 (N) %	8 (N) %	9 (N) %	10 (N) %	TOTAL
WHITES	(3) 0.5	(7) 1.3	(3) 0.5	(8) 1.4	(48) 8.7	(50) 9.0	(42) 7.6	(46) 8.3	(31) 5.6	(56) 10.1	(2911) 53.1
NON-WHITES	(0) 0.0	(3) 0.5	(5) 0.9	(2) 0.4	(34) 6.1	(19) 3.4	(23) 4.2	(38) 6.9	(49) 8.8	(87) 15.7	(2600) 46.9
TOTAL	(3) 0.05	(10) 1.8	(8) 1.4	(10) 1.8	(82) 14.8	(69) 12.5	(65) 11.7	(84) 15.2	(80) 14.4	(143) 25.8	(5511) 100.0

$\chi^2 = 40.168$, 9 df

Table 6. SELF-ARCH SCORES FOR 546 CLIENTS, BY EDUCATION

	1 (N) %	2 (N) %	3 (N) %	4 (N) %	5 (N) %	6 (N) %	7 (N) %	8 (N) %	9 (N) %	10 (N) %	TOTAL
NONE	(1) 0.2	(0) 0.0	(0) 0.0	(0) 0.0	(1) 0.2	(3) 0.5	(0) 0.0	(0) 0.0	(1) 0.2	(3) 0.5	(9) 1.6
1-6 YRS.	(0) 0.0	(3) 0.5	(1) 0.2	(2) 0.4	(12) 2.2	(10) 1.8	(4) 0.7	(15) 2.7	(15) 2.7	(49) 9.0	(111) 20.3
7-12 YRS.	(2) 0.4	(6) 1.1	(6) 1.1	(6) 1.1	(56) 10.3	(49) 9.0	(46) 8.4	(61) 11.2	(57) 10.4	(79) 14.5	(368) 67.4
13-16 YRS.	(0) 0.0	(1) 0.2	(1) 0.2	(2) 0.4	(13) 2.4	(5) 0.9	(13) 2.4	(6) 1.1	(6) 1.1	(7) 1.3	(54) 9.9
SOME GRAD.	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(1) 0.2	(0) 0.0	(0) 0.0	(1) 0.2	(2) 0.4
GRAD DEGREE	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(1) 0.2	(1) 0.2	(0) 0.0	(0) 0.0	(2) 0.4
TOTAL	(3) 0.5	(10) 1.8	(8) 1.5	(10) 1.8	(82) 15.0	(67) 12.3	(65) 11.9	(83) 15.2	(79) 14.5	(139) 25.5	(546) 100.0

$\chi^2 = 79.449$, 45 df.

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Table 7. SELF-ANCHORING SCORES FOR 554 BLIND CLIENTS BY AGE

	1 (N) %	2 (N) %	3 (N) %	4 (N) %	5 (N) %	6 (N) %	7 (N) %	8 (N) %	9 (N) %	10 (N) %	TOTAL
<20 YEARS	(0) 0.0	(3) 0.5	(2) 0.4	(3) 0.5	(10) 1.8	(13) 2.3	(11) 2.0	(20) 3.6	(12) 2.2	(23) 4.2	(97) 17.5
20-29	(1) 0.2	(1) 0.2	(0) 0.0	(2) 0.4	(33) 6.0	(21) 3.8	(26) 4.7	(28) 5.1	(33) 6.0	(43) 7.8	(188) 33.9
30-39	(2) 0.4	(2) 0.4	(2) 0.4	(2) 0.4	(10) 1.8	(11) 2.0	(6) 1.1	(10) 1.8	(16) 2.9	(25) 4.5	(86) 15.5
40-49	(0) 0.0	(2) 0.4	(2) 0.4	(0) 0.0	(15) 2.7	(7) 1.3	(10) 1.8	(12) 2.2	(9) 1.6	(23) 4.2	(80) 14.4
50-59	(0) 0.0	(2) 0.4	(1) 0.2	(3) 0.5	(9) 1.6	(15) 2.7	(8) 1.4	(11) 2.0	(10) 1.8	(26) 4.7	(85) 15.3
60 OR MORE	(0) 0.0	(0) 0.0	(1) 0.2	(0) 0.0	(5) 0.9	(2) 0.4	(4) 0.7	(3) 0.5	(0) 0.0	(3) 0.5	(18) 3.2
TOTAL	(3) 0.5	(10) 1.8	(8) 1.4	(10) 1.8	(82) 14.8	(69) 12.5	(65) 11.7	(84) 15.2	(80) 14.4	(143) 25.8	(554) 100.0

$\chi^2 = 47.114$, 45 df.

Table 8. Self-Anchoring [illegible] for 546 Blind Clients, By Length of Visual Impairment in Years

	1 (N) %	2 (N) %	3 (N) %	4 (N) %	5 (N) %	6 (N) %	7 (N) %	8 (N) %	9 (N) %	10 (N) %	TOTAL
< 10 YRS.	(0) 0.0	(1) 0.2	(2) 0.4	(2) 0.4	(24) 4.4	(21) 3.8	(24) 4.4	(27) 4.9	(24) 4.4	(41) 7.5	(166) 30.4
10-19	(0) 0.0	(4) 0.7	(2) 0.4	(4) 0.7	(24) 4.4	(16) 2.9	(12) 2.2	(25) 4.6	(30) 5.5	(40) 7.3	(157) 28.8
20-29	(1) 0.2	(1) 0.2	(1) 0.2	(0) 0.0	(16) 2.9	(16) 2.9	(20) 3.7	(16) 2.9	(16) 2.9	(31) 5.7	(118) 21.6
30-39	(2) 0.4	(2) 0.4	(2) 0.4	(3) 0.5	(9) 1.6	(3) 0.5	(5) 0.9	(7) 1.3	(7) 1.3	(15) 2.7	(55) 10.1
40-49	(0) 0.0	(2) 0.4	(1) 0.2	(0) 0.0	(4) 0.7	(3) 0.5	(4) 0.7	(6) 1.1	(1) 0.2	(10) 1.8	(31) 5.7
50-59	(0) 0.0	(0) 0.0	(0) 0.0	(1) 0.2	(3) 0.5	(6) 1.1	(0) 0.0	(2) 0.4	(2) 0.4	(4) 0.7	(18) 3.3
60 OR MORE	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(1) 0.2	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(1) 0.2
TOTAL	(3) 0.5	(10) 1.8	(8) 1.5	(10) 1.8	(80) 14.7	(66) 12.1	(65) 11.9	(83) 15.2	(80) 14.7	(141) 25.8	(546) 100.0

$\chi^2 = 63.836$, 54 df.

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Table 9. SELF ANCHORING SCORE FOR 551 BLIND CLIENTS, BY RESIDENCE

	1 (N) %	2 (N) %	3 (N) %	4 (N) %	5 (N) %	6 (N) %	7 (N) %	8 (N) %	9 (N) %	10 (N) %	TOTAL
OPEN COUNTRY FARM	(0) 0.0	(3) 0.5	(2) 0.4	(3) 0.5	(19) 3.4	(17) 3.1	(14) 2.5	(20) 3.6	(10) 1.8	(33) 6.0	(121) 22.0
OPEN COUNTRY NON FARM	(0) 0.0	(0) 0.0	(1) 0.2	(1) 0.2	(7) 1.3	(5) 0.9	(3) 0.5	(3) 0.5	(11) 2.0	(15) 2.7	(46) 8.3
SMALL TOWN FARM	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(1) 0.2	(4) 0.7	(4) 0.7	(6) 1.1	(3) 0.5	(12) 2.2	(30) 5.4
SMALL TOWN <2500	(1) 0.2	(2) 0.4	(0) 0.0	(0) 0.0	(7) 1.3	(9) 1.6	(7) 1.3	(9) 1.6	(7) 1.3	(7) 1.3	(49) 8.9
2500 TO 10,000	(0) 0.0	(1) 0.2	(2) 0.4	(1) 0.2	(14) 2.5	(15) 2.7	(9) 1.6	(12) 2.2	(10) 1.8	(17) 3.1	(81) 14.7
10,001 TO 50,000	(1) 0.2	(1) 0.2	(0) 0.0	(1) 0.2	(10) 1.8	(6) 1.1	(8) 1.5	(7) 1.3	(7) 1.3	(14) 2.5	(55) 10.0
50,000 AND OVER	(1) 0.2	(3) 0.5	(3) 0.5	(4) 0.7	(24) 4.4	(12) 2.2	(20) 3.6	(26) 4.7	(31) 5.6	(44) 8.0	(168) 30.5
OTHER	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(0) 0.0	(1) 0.2	(0) 0.0	(0) 0.0	(1) 0.2
TOTAL	(3) 0.5	(10) 1.8	(8) 1.5	(10) 1.8	(82) 14.9	(68) 12.3	(65) 11.8	(84) 15.2	(79) 14.3	(142) 25.8	(551) 100.0

$\chi^2 = 51.144$, 63 df.

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As the so-called worst kind of person was described as being at the lower end of the scale, and the best kind of person at the higher numbered end, it is seen in Table 1 that, the large majority of clients placed themselves at the middle at least, with 16.8 per cent of the clinic interviewees placing themselves in the 10 category, as opposed to only 9 per cent of the field ones. Table 2 (page 3) describes the sample in regard to the amount of vision they have when attending the Clinic. Blindness is legally defined, and it is often the case that persons with quite a bit of residual vision are still categorized as legally blind, while one eye might be perfect and the other very poor.

In Table 3, those born blind and those who became blind later in life are looked at; it is interesting to note that the non-congenital group consistently rate themselves higher at the positive end of the scale. Tables 4, 5, and 6 refer to the percentages of clients in each of the steps of the scale for sex, race, and education, respectively. The age factor, referred to in Table 7 has emerged as an important one in past studies on blindness (Rawls and Rawls, 1968, for instance). This author has found younger clients (less than 30) to have significantly better self concepts than the ones 30 years of age and over. Therefore, for the present set of data, the age factor may prove to be a very interesting one for future analyses.

Not a great deal has been looked at yet concerning how long someone has been impaired, in relation to self-concept.. Table 8 shows how 546 clients in the sample distributed themselves along the 10 categories of the self-anchoring technique for scaling. In Table 9, residence is broken down into several categories with the thought that finer distinctions may yield more interesting findings. The distinction between small town less than 2500 and the small town farm could possibly bring forth conclusions concerning the life styles of the communities in question, and the influences that community variables widely understood to exist exert. It is the work for future analyses of the data to bring out new findings and support old ones, or not support them, as the case may be, especially concerning rural-urban differentials.

Summary and Conclusions

The authors of this paper contend that person perception and self-other roles are especially pertinent phenomena to be con-

sidered when studying blindness. It is hoped that insight into the self-concepts of the visually impaired will yield information pertinent to the task of helping such persons adjust in the community. As a medical disability, blindness is of great interest to doctors as well as counselors, social workers, and other helping persons. We feel that it is of sociological interest to study how blind persons view themselves. It has often been pointed out in the literature that blind persons do not wish to be separate from other societal groups, but they in fact are quite separate. Knowledge about how they see themselves in relation to others is needed in order to help them become a permanent part of the larger group.

In utilizing a self-anchoring technique, the authors have attempted to allow a degree of flexibility to self-reporting procedures, while at the same time keeping the procedure as simple as possible. Such a technique produces both quantitative and qualitative measures of how one views himself in relation to his peers. It is expected that reports will be forthcoming shortly fully analyzing such information. Finally, the kind of data with which this report is concerned ought to be of interest to the social psychologists and social psychiatrists among you in that it reveals information about persons that only they can provide--as they perceive it. In future content analyses, the dynamics of community adjustment will emerge, from the viewpoint of the person doing the adjusting. It may be that from that vantage point visually impaired and other disabled persons may be best understood.

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